DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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SUBJECT: Memorandum Report: *Utilization of Medicare Ambulance Transports, 2002–2011*, OEI-09-12-00350

This memorandum report provides an overview of the changes in utilization of Medicare Part B ambulance transports from 2002 through 2011.

SUMMARY

The number of ambulance transports reimbursed by Medicare Part B increased 69 percent from 2002 to 2011. This memorandum report provides information about the patterns of this utilization growth. In a forthcoming report, the Office of Inspector General (OIG) will identify ambulance suppliers that exhibited characteristics of questionable billing in the first half of 2012 and geographic areas with high numbers of these suppliers.

From 2002 to 2011, the number of Medicare fee-for-service beneficiaries who received transports and the number of ambulance suppliers both increased. The number of beneficiaries who received transports increased 34 percent, although the total number of Medicare fee-for-service beneficiaries increased just 7 percent during the same period. The number of ambulance suppliers increased 26 percent. In addition, the number of ambulance suppliers that primarily provided basic life support (BLS) nonemergency transports nearly doubled.

The increase in ambulance transports from 2002 to 2011 varied by the origin and destination of the transport. The number of transports to or from independent dialysis facilities (dialysis-related transports) increased 269 percent. Further, beneficiaries with end stage renal disease (ESRD), a condition that often requires dialysis treatment, used a

growing and disproportionate amount of transports each year.[1] Although transports to or from hospitals increased at a significantly slower rate from 2002 to 2011 (55 percent) than did dialysis-related transports, they represented a larger proportion of all transports (79 percent). Outpatient visits to receive partial hospitalization program services at community mental health centers by beneficiaries who received transports increased 829 percent.[2]

We also found that although all States experienced increases in transports from 2002 to 2011, utilization changes varied widely by State. States with particularly high growth in ambulance utilization experienced increases in dialysis-related transports that were greater than the national increase. These States also experienced increases that were greater than the national increase in BLS nonemergency transports and in inpatient hospital visits to treat renal failure in beneficiaries who received transports.

BACKGROUND

Utilization of Medicare Ambulance Transports

Medicare Part B payments for ambulance transports continue to grow at a faster rate than all Medicare Part B payments. In 1998, OIG reported that Medicare Part B payments for ambulance transports "more than tripled between 1987 and 1996—from $602 million to almost $2.1 billion," although during this time all Medicare Part B payments doubled.[3, 4] This trend continued after that period. From 2002 to 2011, Medicare Part B payments for ambulance transports increased 130 percent, from $2.0 billion to $4.5 billion.[5] During this period, all Medicare Part B payments increased 74 percent.[6]

Several factors have contributed to the increase in payments for ambulance transports. The increase was caused in part by inflation and the transition to the national fee schedule for Medicare ambulance transports, which was phased in from 2002 through 2005.[7]

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[1] ESRD is permanent kidney failure that requires a regular course of dialysis or a kidney transplant. Centers for Medicare & Medicaid Services (CMS), *Medicare Coverage of Kidney Dialysis & Kidney Transplant Services*. Accessed at http://www.medicare.gov/Pubs/pdf/10128.pdf, p. 53 on July 3, 2013.

[2] Partial hospitalization programs provide intensive psychiatric care and resemble structured, short-term hospital inpatient programs. Patients admitted to a partial hospitalization program (1) do not require 24-hour supervision as provided in an inpatient setting, (2) must have a support system outside the program, and (3) must not be an imminent danger to themselves or others. CMS, *Medicare Benefit Policy Manual*, ch. 6 § 70.3.

[3] OIG, *Medical Necessity of Medicare Ambulance Services*, OEI-09-95-00412, December 1998.

[4] Medicare Part B payments totaled $28.4 billion in 1987 and $59.1 billion in 1996. CMS, *Medicare and Medicaid Statistical Supplement*. 2001 Edition, Table 12.

[5] OIG analysis of CMS Physician/Supplier Part B claims file. Total Medicare-allowed amounts increased from $2.5 billion to $5.7 billion.

[6] Medicare Part B payments totaled $92.4 billion in 2002 and $160.9 billion in 2011. CMS, *Medicare and Medicaid Statistical Supplement*. 2012 Edition, Table 3.3.

[7] Ambulance fee-schedule amounts are adjusted for inflation using the urban consumer price index, which increased 25 percent from 2002 to 2011. After taking inflation into account, average allowances are an estimated 3 percent higher than they were before the national fee schedule was implemented. United States Government Accountability Office (GAO), *Ambulance Providers: Costs and Expected Margins Vary Greatly*, GAO-07-383, p. 6.

Continued growth in the utilization of transports has also contributed to the increase. From 2002 to 2011, the number of Medicare ambulance transports increased 69 percent (from 8.7 million to 14.8 million).[8]

Findings from past OIG reports indicate that the ambulance benefit is vulnerable to abuse. One report found that in 1996, two-thirds of ambulance transports that did not result in expected hospital or nursing home admissions or emergency room care were medically unnecessary.[9] Another report found that 25 percent of ambulance transports in 2002 did not meet Medicare program requirements, resulting in an estimated $402 million in improper payments.[10] The report also found that 27 percent of transports to and from independent dialysis facilities in 2002 did not meet coverage requirements.

Recent cases involving ambulance suppliers also indicate that the ambulance benefit is vulnerable to fraud. For example, in October 2012, administrators of a Houston-based ambulance supplier pleaded guilty to submitting claims for $1.7 million to Medicare for transports that were miscoded, not medically necessary, and in some cases, not provided.[11] In February 2013, an ambulance supplier operating in South Carolina paid $800,000 to settle allegations that it fraudulently billed Medicare for routine, nonemergency transports that were not medically necessary and that it created fraudulent documents to support the transports.[12]

Medicare Coverage of Ambulance Transports

Medicare covers ambulance transports when a beneficiary's medical condition at the time of transport is such that using other means of transportation would endanger the beneficiary's health.[13, 14] In addition, the transport must be to receive a Medicare-covered service or to return from such a service.[15] Medicare does not limit the number of ambulance transports per beneficiary.[16] Medicare does not cover means of transport other than ambulance.

Covered destinations. A medically necessary ambulance transport may be covered to and from the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic

[8] OIG analysis of 2002 and 2011 Physician/Supplier Part B claims file.
[9] OIG, *Medical Necessity of Medicare Ambulance Services*, OEI-09-95-00412, December 1998.
[10] OIG, *Medicare Payments for Ambulance Transports*, OEI-05-02-00590, January 2006.
[11] United States Department of Justice, *Houston Ambulance Company Administrator Pleads Guilty to Fraud*. Accessed at http://www.justice.gov/opa/pr/2012/October/12-crm-1242.html on March 1, 2013.
[12] United States Department of Justice, *South Carolina Ambulance Company to Pay U.S. $800,000 to Resolve False Claims Allegations*. Accessed at http://www.justice.gov/opa/pr/2013/February/13-civ-232.html on March 1, 2013.
[13] CMS, *Medicare Benefit Policy Manual*, ch. 10 § 10.2.1.
[14] Although they are not required to do so, suppliers may include on a transport claim a diagnosis code that characterizes the beneficiary's medical condition at the time of transport. This diagnosis code is used by suppliers to communicate the beneficiary's condition as reported by the dispatch center and as observed by the ambulance crew.
[15] CMS, *Medicare Benefit Policy Manual*, ch. 10 § 10.2.1.
[16] Social Security Act § 1861(s)(7).

services.[17] Medicare covers ambulance transports only to hospitals (including critical access hospitals), skilled nursing facilities, the beneficiary's home, and (for beneficiaries with ESRD who require dialysis) dialysis facilities.[18]

Although dialysis facilities are a covered destination, transports to them do not usually meet coverage requirements under Medicare.[19] One Medicare Administrative Contractor estimated that 10 percent of beneficiaries who receive hemodialysis—one of the two main types of dialysis—require ambulance transportation to receive treatment.[20] Beneficiaries who receive dialysis typically have three dialysis sessions per week.[21] Therefore, beneficiaries who require transportation by ambulance to dialysis facilities would typically receive six transports per week.

Transport levels. Medicare covers seven levels of ground ambulance transports (transport levels).[22] Each transport level is billed using a Health Care Procedure Coding System code (procedure code). Table 1 lists each procedure code, transport level, the corresponding total amount allowed by Medicare, the total number of transports, and the average allowed amount per transport by Medicare in 2011.

Table 1: Medicare Allowances in 2011 for Ambulance Transports and Corresponding Mileage, by Procedure Code

Procedure Code	Transport Level	Total Allowed Amount*	Number of Transports	Average Allowed Amount per Transport*
A0426	Advanced life support (ALS) nonemergency	$153,146,601	318,886	$480
A0427	ALS emergency	$2,336,057,963	4,859,616	$481
A0428	BLS nonemergency	$1,938,054,934	6,714,246	$289
A0429	BLS emergency	$1,084,838,255	2,643,313	$410
A0432	Paramedic ALS intercept	$1,137,377	13,079	$87
A0433	ALS2	$76,074,065	112,038	$679
A0434	Specialty care transport	$91,540,103	103,641	$883

*Includes amounts allowed for corresponding mileage for these transports. Mileage, billed using procedure code A0425, is billed together with the transport procedure code. Mileage does not apply to paramedic ALS intercepts transports. Dollar amounts have been rounded to the nearest whole number.

Source: OIG analysis of 2011 Medicare Part B ambulance transports, 2013.

The transport levels are distinguished by the qualifications of the ambulance crew and the medical care provided.[23] All BLS transports require an ambulance crew certified at least

[17] CMS, *Medicare Benefit Policy Manual*, ch. 10 § 10.3. "Appropriate facility" means that the institution is generally equipped to provide the needed hospital care or skilled nursing care for the illness or injury.
[18] CMS, *Medicare Benefit Policy Manual*, ch. 10 § 10.3.
[19] Palmetto GBA, *Nonemergency Services*. Accessed at http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Jurisdiction%201%20Part%20B~Browse%20by%20Specialty~Ambulance~8EEMHW2614?open&navmenu=Browse^by^Specialty|||| on May 1, 2012.
[20] Novitas Solutions, Inc., *Ambulance (Grounds) Services L32252*.
[21] CMS, *Medicare Benefit Policy Manual*, ch. 11 § 30.1.
[22] Medicare also covers air ambulance transports by airplane and helicopter.
[23] CMS, *Medicare Benefit Policy Manual*, ch. 10 § 30.1.1. This chapter defines the transport levels.

as basic emergency medical technicians.[24] All ALS transports require an ambulance crew certified at least as intermediate or paramedic emergency medical technicians. For the ambulance transport to be covered as an ALS transport, the beneficiary's condition must require an assessment or a service that can be provided only by an ALS crew. Paramedic ALS intercept transports and ALS2 transports are variations of ALS transports.[25] Specialty care transports are interfacility transports for critically injured or ill beneficiaries and require that the ambulance crew include a health professional specialist (e.g., emergency nurse) or a paramedic emergency medical technician with additional training.

The transport level depends not only on the level of service, but also on whether the transport is provided in an emergency or nonemergency situation.[26] Emergency transports are provided according to the protocol of the local 911 or equivalent dispatch.[27] Lack of immediate medical attention in these cases could reasonably be expected to place the beneficiary's health in jeopardy, result in serious impairment of bodily functions, or result in serious dysfunction of any bodily organ. Symptoms or conditions that may warrant an emergency transport include, but are not limited to, severe pain, bleeding, or unconsciousness.[28] Nonemergency transports are provided in the absence of an emergency to beneficiaries who are bed-confined before and after transportation, or when transportation by ambulance is medically required.[29, 30] Nonemergency transports may be scheduled or unscheduled and may be one-time or recurring.

Medicare covers mileage to and from the nearest appropriate facility when the ambulance transport is covered.[31] Only miles traveled with the beneficiary onboard are covered.

Related Work

Both GAO and the Medicare Payment Advisory Commission (MedPAC) have reported on the growth in ambulance utilization as part of their work on Medicare Part B payments for ambulance transports. In October 2012, GAO reported on the effect of the ambulance

[24] State and local laws that establish qualifications for emergency medical technicians vary. For example, only in some jurisdictions are basic emergency medical technicians permitted to establish a peripheral intravenous line.

[25] Paramedic intercept transports are provided when a BLS ambulance is dispatched, but the beneficiary needs ALS service. For these transports, a paramedic emergency medical technician meets the BLS ambulance at the scene or once the ambulance is on the way to the hospital. ALS2 transports include the provision of at least three separate administrations of one or more medications or the provision of at least one ALS2 procedure (e.g., central venous line, chest decompression).

[26] CMS, *Medicare Benefit Policy Manual*, ch. 10 § 30.1.1.

[27] Ibid.

[28] CMS, *Medicare Coverage of Ambulance Services*, pp. 5–6. Accessed at http://www.medicare.gov/Publications/Pubs/pdf/11021.pdf on May 25, 2012.

[29] CMS, *Medicare Benefit Policy Manual*, ch. 10 § 10.2.3. To be considered bed-confined, the beneficiary must be unable to get up from bed without assistance, ambulate, or sit in a chair or wheelchair.

[30] While bed-confinement is important in determining the appropriateness of nonemergency ambulance transports, bed-confinement alone is neither sufficient nor necessary to determine coverage for Medicare's ambulance benefit.

[31] CMS, *Medicare Benefit Policy Manual*, ch. 10 § 10.3. Mileage is billed on the same claim as the transport using procedure code A0425.

fee schedule on beneficiaries' access to care. GAO noted that the increase in utilization from 2004 to 2010 was due primarily to an increase in BLS nonemergency transports, and that the increase was the greatest in super-rural areas.[32] In addition to fraud and abuse, the GAO report cites the following as potential reasons for utilization increases: (1) new or increased billing by local governments under budgetary pressures that previously refrained from billing Medicare for transports and (2) the introduction of the national fee schedule for ambulance transports.[33] In June 2013, MedPAC reported on the ambulance fee schedule. MedPAC also noted that the utilization of BLS nonemergency transports, particularly those that were dialysis-related, grew faster than the utilization of other transport levels from 2007 to 2011.[34]

OIG is conducting additional analysis of national Medicare ambulance claims data. This analysis will identify ambulance suppliers that exhibited characteristics of questionable billing in the first half of 2012, as well as geographic areas with high numbers of these suppliers.

METHODOLOGY

Scope

This evaluation is national in scope and is based on all claims for ground ambulance transports from CMS's Physician/Supplier Part B claims files from 2002 to 2011. We analyzed claims billed under the procedure codes A0425–A0429 and A0433–A0434.[35] We did not review transports billed by institution-based ambulance suppliers.[36] We analyzed only transports for which mileage was also billed.[37]

We did not review the medical records of beneficiaries who received transports. Therefore, we did not determine whether the transports were medically necessary or met coding and documentation requirements for coverage. Generally, we cannot conclude whether fraud, waste, or abuse, or other potential reasons—such as new or increased billing by local governments or the introduction of the national ambulance fee schedule—caused the changes in ambulance utilization that we report.

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[32] Super-rural areas have population densities lower than rural areas. GAO, *Costs and Margins Varied Widely; Transports of Beneficiaries Have Increased*, GAO-13-6, October 2012.

[33] Ibid.

[34] Ambulance suppliers in this report include independent and institution-based ambulance suppliers. MedPAC, *Report to the Congress, Medicare and the Health Care Delivery System*, ch. 7, Mandated report: *Medicare payment for ambulance services*, pp. 178-179, June 2013.

[35] We did not analyze claims for paramedic ALS intercept transports, which accounted for less than one-tenth of 1 percent of all transports and were provided only in New York. In our analysis, we also included mileage procedure codes A0380 and A0390 and transport procedure codes Q3019 and Q3020, which were phased out as part of the transition to the national fee schedule.

[36] Four percent of ambulance suppliers in 2011 were institution-based suppliers. OIG analysis of CMS's 2011 Outpatient 100-percent Standard Analytic File.

[37] In 2011, less than 2 percent of transports were billed without mileage. These include paramedic ALS intercept transports and transports for which the beneficiary died after the ambulance was dispatched but before it arrived.

Data Sources and Analysis

We used CMS's Physician/Supplier Part B claims file, the Denominator file for 2002 through 2011, and the Medicare Enrollment Database for 2011. We also used CMS's Inpatient and Outpatient 100-percent Standard Analytic Files for 2002 and 2011. The Physician/Supplier Part B claims file contains claims submitted by independent ambulance suppliers and other noninstitutional providers such as physicians, physician assistants, and nurse practitioners. The Denominator file and Medicare Enrollment Database both contain enrollment information, such as date of birth and eligibility category, about each Medicare beneficiary. The Inpatient and Outpatient Standard Analytic Files contain claims submitted by institutions, such as hospitals. We used the 18-month files, which include claims processed as of June 30th of the year following the dates of service.

We determined the extent to which the utilization of ambulance services changed from 2002 to 2011. For each year, we analyzed the characteristics of beneficiaries, suppliers, and transports and calculated the percentage differences since 2002. We also calculated changes in utilization by State. Furthermore, we calculated the change in certain transport characteristics in the States with the largest utilization increases that also accounted for at least 3 percent of 2011 transports nationally (high-growth States). See Appendix A for more details of our data analysis.

This inspection was conducted in accordance with the *Quality Standards for Inspection and Evaluation* approved by the Council of the Inspectors General on Integrity and Efficiency.

RESULTS

The Number of Beneficiaries Who Received Transports Increased 34 Percent, Compared With the 7-Percent Increase in All Fee-For-Service Medicare Beneficiaries, From 2002 to 2011

Over 1 million more beneficiaries received transports in 2011 than in 2002, an increase of 34 percent. In 2002, 3.6 million beneficiaries received transports, compared with 4.8 million beneficiaries in 2011. In contrast, the number of Medicare fee-for-service beneficiaries increased just 7 percent from 2002 to 2011.

On average, beneficiaries received more transports. Among beneficiaries receiving transports, the number of transports a beneficiary received each year increased from an average of 2.4 in 2002 to an average of 3.1 in 2011.

Beneficiaries who received transports were younger, on average, and more likely to be eligible for Medicare because of a disability in 2011 than in 2002. The average age of beneficiaries who received transports decreased from 76.7 years to 75.4 years. This change resembled that of the Medicare fee-for-service population, among whom the average age decreased from 70.6 years to 69.7 years. The percentage of beneficiaries who received transports and were eligible because of a disability increased from 13 percent in 2002 to 19 percent in 2011. Similarly, the percentage of Medicare

fee-for-service beneficiaries who were eligible because of a disability increased from 15 percent in 2002 to 18 percent in 2011. Table 2 presents the percentages of beneficiaries who received transports by their Medicare eligibility status from 2002 to 2011.

Table 2: Percentage of Beneficiaries Who Received Transports From 2002 to 2011, by Medicare Eligibility Status

Year	Aged 65 and Over Without ESRD	Disabled (Under 65 and Without ESRD)	Has ESRD (Regardless of Age or Disability Status)*
2002	85.1%	13.0%	2.3%
2003	84.4%	13.6%	2.7%
2004	83.2%	14.4%	3.0%
2005	82.6%	15.0%	3.1%
2006	82.2%	15.2%	3.3%
2007	81.5%	15.7%	3.4%
2008	81.1%	16.1%	3.4%
2009	80.4%	16.7%	3.6%
2010	80.0%	17.4%	3.3%
2011	78.3%	18.8%	3.2%

*There are five Medicare eligibility categories. We combined into a single category the three categories of beneficiaries with ESRD. (These three categories distinguish ESRD beneficiaries by age and disability status.)

Source: OIG analysis of 2002 to 2011 Medicare Part B ambulance transports, 2013.

Note: Percentages do not add to 100 percent because transport-receiving beneficiaries whose age or ESRD status changed during the course of the year were counted more than once.

Less than 1 percent of beneficiaries who received transports were counted more than once in each year.

Twenty-Six Percent More Ambulance Suppliers Provided Transports in 2011 Than in 2002

Over 3,500 more ambulance suppliers provided transports in 2011 than in 2002 and, on average, suppliers provided more transports. The number of suppliers increased 26 percent (from 14,087 to 17,776). Additionally, suppliers provided an average of 34 percent more transports in 2011 than in 2002 (increasing from 619 to 830 transports per supplier).

Ambulance suppliers billed for greater average transport distances. The average trip length increased 1.6 miles (from 7.8 to 9.4 miles). Furthermore, suppliers billed for longer-mileage transports—i.e., those that were more than 20 miles—111 percent more often in 2011 than in 2002. However, Medicare beneficiaries were no more likely to live in a rural location in 2011 than in 2002.[38]

[38] In 2002, 31.2 million Medicare beneficiaries lived in urban locations and 9.3 million in rural locations. In 2011, 39.1 million Medicare beneficiaries lived in urban locations and 9.8 million in rural locations. CMS, *Medicare and Medicaid Statistical Supplement*. 2004 Edition, Table 6, and 2012 Edition, Table 2.3.

The number of ambulance suppliers that primarily provided BLS nonemergency transports nearly doubled.[39] The number of ambulance suppliers that primarily provided a single transport level increased from 2002 to 2011. In particular, the number of suppliers that primarily provided BLS nonemergency transports increased 92 percent during this period. In 2002, these suppliers represented 7 percent of all suppliers and billed for 16 percent of all transports. In 2011, they represented 11 percent of suppliers and billed for 30 percent of all transports. Table 3 presents the growth in the numbers of suppliers that usually provided a single transport level.

Table 3: Ambulance Suppliers That Primarily Provided a Single Transport Level in 2002 and 2011

Year	Suppliers That Primarily Provided BLS Nonemergency Transports	Suppliers That Primarily Provided ALS Emergency Transports	Suppliers That Primarily Provided Another Single Transport Level*	Suppliers That Provided a Mix of Transport Levels	All Suppliers
2002	981	2,862	2,839	7,405	14,087
2011	1,881	4,060	3,067	8,768	17,776
Percentage Change	92%	42%	8%	18%	26%

*Most of these suppliers primarily provided BLS emergency transports (94 percent in 2002 and 97 percent in 2011).

Source: OIG analysis of 2002 to 2011 Medicare Part B ambulance transports, 2013.

The number of suppliers that primarily provided ALS emergency transports also increased at a greater rate than the overall number of suppliers. In 2002, these suppliers represented 20 percent of all suppliers and billed for 8 percent of all transports. In 2011, they represented 23 percent of suppliers and billed for 10 percent of all transports.

In addition to the growth in the numbers of suppliers that primarily provided BLS nonemergency transports or ALS emergency transports, the overall use of these transport levels increased more than that of other transport levels. In 2002, beneficiaries received 3.5 million BLS nonemergency transports, a figure that increased to 6.7 million in 2011 (a 94-percent increase). Similarly, the total number of ALS emergency transports increased from 2.9 million in 2002 to 4.9 million in 2011 (a 68-percent increase). See Appendix B for the changes from 2002 to 2011 in the use of each transport level.

The Number of Dialysis-Related Transports Increased 269 Percent From 2002 to 2011

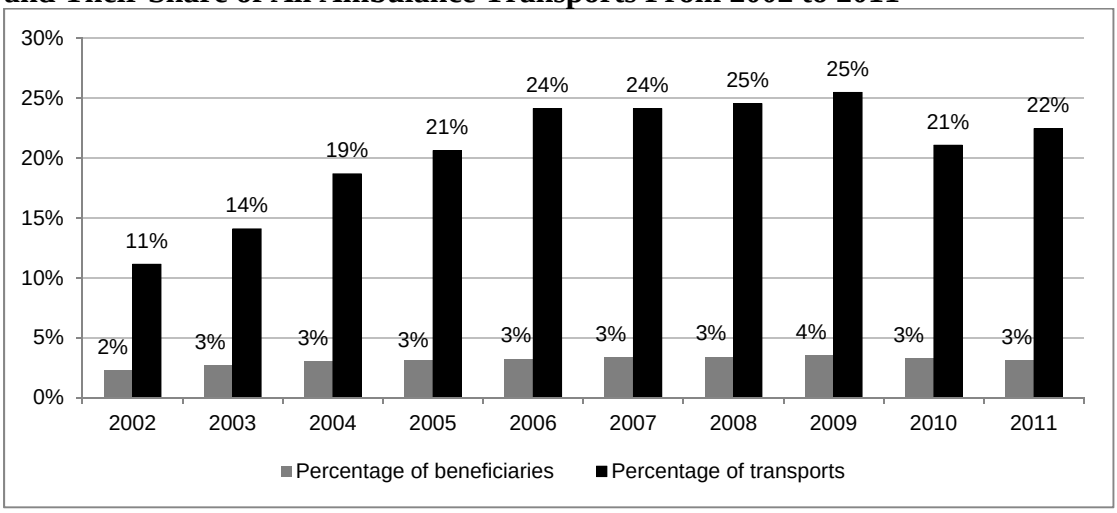
Dialysis-related transports increased the most, compared with transports to or from other origins and destinations.[40] These transports increased 269 percent (from 753,741 to 2,780,323). They represented 9 percent of all transports in 2002 and 19 percent of all transports in 2011.

[39] For the purpose of this report, we use the term "primarily provided" to mean those suppliers for which a single transport level accounted for at least 75 percent of the supplier's transports.

[40] We considered a transport to be dialysis-related if the two-letter modifier on the claim indicated an independent dialysis facility as the origin or destination.

Beneficiaries with ESRD who received transports accounted for an increasing percentage of all ambulance transports. Although beneficiaries with ESRD did not make up a large percentage of beneficiaries who received transports, this group used a growing and disproportionate number of transports. From 2002 to 2011, the percentage of beneficiaries with ESRD who received transports varied little. However, the percentage of transports associated with these beneficiaries increased from 11 percent to 22 percent. Most of these transports were dialysis-related. Figure 1 presents the percentage of beneficiaries with ESRD who received transports and their share of all transports from 2002 through 2011.

Figure 1: Percentage of Beneficiaries With ESRD Who Received Transports and Their Share of All Ambulance Transports From 2002 to 2011



Source: OIG analysis of 2002 to 2011 Medicare Part B ambulance transports, 2013.
Note: Percentages are rounded to the nearest whole number.

More Medicare fee-for-service beneficiaries with ESRD received transports and, on average, received a greater number of transports in 2011 than in 2002. The number of transport-receiving Medicare fee-for-service beneficiaries with ESRD increased 85 percent. In contrast, the number of all Medicare fee-for-service beneficiaries with ESRD increased 24 percent during the same period. In addition, the average number of transports a beneficiary with ESRD received each year increased from 12 transports to 21 transports.

The Number of Transports To or From Hospitals Increased 55 Percent From 2002 to 2011

The number of transports to or from hospitals increased significantly less than the number of dialysis-related transports but accounted for 79 percent of all transports in 2011.[41] The number of transports to or from hospitals increased 55 percent, from 7.5 million in 2002 to 11.7 million in 2011. In 2011, over three-quarters of transports to or from hospitals had hospitals as their destinations (for example, from the beneficiary's

[41] We considered a transport to be to or from the hospital if the two-letter modifier indicated a hospital as the origin or destination.

residence to the hospital), and the remainder were from hospitals to other destinations. Between 2002 and 2011, there were changes in the origins, transport levels, medical conditions of beneficiaries at the time of transport, and destination facilities of transports to hospitals.

The origins of transports to hospitals changed. Notably, transports to hospitals originating from the scene of an accident or acute event increased 112 percent from 2002 to 2011, representing 13 percent of transports to hospitals in 2011. Transports originating from a residence increased 51 percent, representing half of all transports to hospitals in 2011.

Suppliers provided certain levels of transports more frequently for transports to hospitals. Emergency transports to hospitals increased 65 percent from 2002 to 2011, compared with the 14-percent increase in nonemergency transports to hospitals. The type of emergency transport level that increased the most was ALS emergency transports, which increased 69 percent and represented 55 percent of all transports to hospitals in 2011. BLS emergency transports increased 60 percent from 2002 to 2011, and represented 30 percent of transports to hospitals in 2011.

For transports to hospitals, the respective prevalences of 15 diagnosis codes that represent the beneficiary's medical condition at the time of transport increased at least 100 percent.[42] Of all the diagnosis codes used to report the beneficiary's medical condition at the time of transport, 15 codes were reported more than twice as often in 2011 than in 2002 among transports to hospitals.[43] Transports using these 15 codes represented a combined 35 percent of transports to hospitals in 2011. See Table 4 for the changes from 2002 to 2011 in medical conditions reported at the time of transport among transports to hospitals.

[42] This analysis is based on transports to hospitals for which the supplier reported the diagnosis code that represents the beneficiary's medical condition at the time of transport. The diagnosis code was reported on 92 percent and 100 percent of transport claims in 2002 and 2011, respectively. OIG analysis of 2002 and 2011 CMS Physician/Supplier Part B claims file.

[43] We report only the diagnosis codes that each represented at least 0.5 percent of transports to hospitals in 2011.

Table 4: Most Frequent Medical Conditions Reported at the Time of Transport Among Transports to Hospitals by Percentage Change From 2002 to 2011

Medical Condition at the Time of Transport	Percentage Change, 2002–2011	Percentage of 2011 Transports
Gastritis and duodenitis	3,090%	0.7%
Crushing injury or internal injury	939%	0.8%
Diabetes mellitus without complication	606%	0.7%
Other fractures	468%	1.1%
Other nervous system disorders	239%	1.4%
Schizophrenia and other psychotic disorders	193%	1.5%
Residual codes, unclassified	176%	13.1%
Other circulatory disease	143%	1.8%
Other injuries and conditions due to external causes	143%	5.8%
Headache, including migraine	136%	1.0%
Complication of device, implant, or graft	135%	0.7%
Delirium, dementia, and amnestic and other cognitive disorders	133%	0.7%
Nausea and vomiting	128%	2.6%
Open wounds of extremities	123%	0.5%
Other connective tissue disease	101%	2.1%

Source: OIG analysis of 2002 and 2011 Medicare Part B ambulance transports, 2013.
Note: Includes only those conditions that account for more than 0.5 percent of 2011 transports to hospitals.

Not all transports that were billed using the destination modifier code for hospitals were to hospitals; the number of transports to nonhospital facilities increased. Transports to hospitals resulted in outpatient visits at hospitals and nonhospital facilities more often than inpatient hospital visits. Beneficiaries who received transports made 40 percent more outpatient hospital visits in 2011 than in 2002 (from 3.6 million visits in 2002 to 5.0 million in 2011). In contrast, all Medicare fee-for-service beneficiaries made 20 percent more outpatient hospital visits. Beneficiaries who received transports made 37 percent more outpatient visits at nonhospital facilities (from 373,734 visits in 2002 to 512,963 visits in 2011).[44] In contrast, all Medicare fee-for-service beneficiaries made 27 percent more outpatient visits at nonhospital facilities. The number of inpatient hospital visits made by beneficiaries who received transports increased 13 percent (from 3.3 to 3.7 million), mirroring the increase in inpatient hospital admissions from 2002 to 2011.

The number of outpatient visits to certain nonhospital facilities made by beneficiaries who received transports increased greatly. In particular, between 2002 and 2011 there was an 829-percent increase in visits by beneficiaries who received transports to receive partial hospitalization program services at community mental health

[44] Although beneficiaries who received transports visited nonhospital facilities such as community mental health centers and dialysis facilities, the associated transports were billed by the supplier as though they involved a visit to a hospital.

centers.[45] In contrast, all outpatient visits to receive partial hospitalization program services at community mental health centers increased only 157 percent during this period. See Table 5 for the types of visits and facilities associated with transports to hospitals.

Table 5: Types of Visits and Facilities Associated With Ambulance Transports to Hospitals by Percentage Change From 2002 to 2011

Types of Visits and Facilities	Percentage Change, 2002–2011	Percentage of Visits Associated With Transports to Hospitals in 2011
Inpatient visits at hospitals	13%	40.3%
Outpatient visits at hospitals*	40%	54.2%
Outpatient visits at nonhospital facilities**	37%	5.5%
Community mental health centers	*829%*	*0.1%*
Federally qualified health centers	*142%*	*0.7%*
Independent dialysis facilities	*62%*	*1.9%*
Rural health clinics	*67%*	*0.9%*

*Includes critical access hospitals and Medicare Part B services provided to inpatient beneficiaries without Part A coverage.

**We report the facility types with the greatest increases from 2002 to 2011.

Source: OIG analysis of 2002 to 2011 Medicare Part B ambulance transports, 2013.

Beneficiaries were transported to hospitals for inpatient visits to treat certain conditions more frequently in 2011 than in 2002.[46] Visits to treat septicemia increased 164 percent, visits to treat renal failure increased 158 percent, and visits related to rehabilitation increased 99 percent.

Increases in Ambulance Utilization From 2002 to 2011 Varied Widely by State

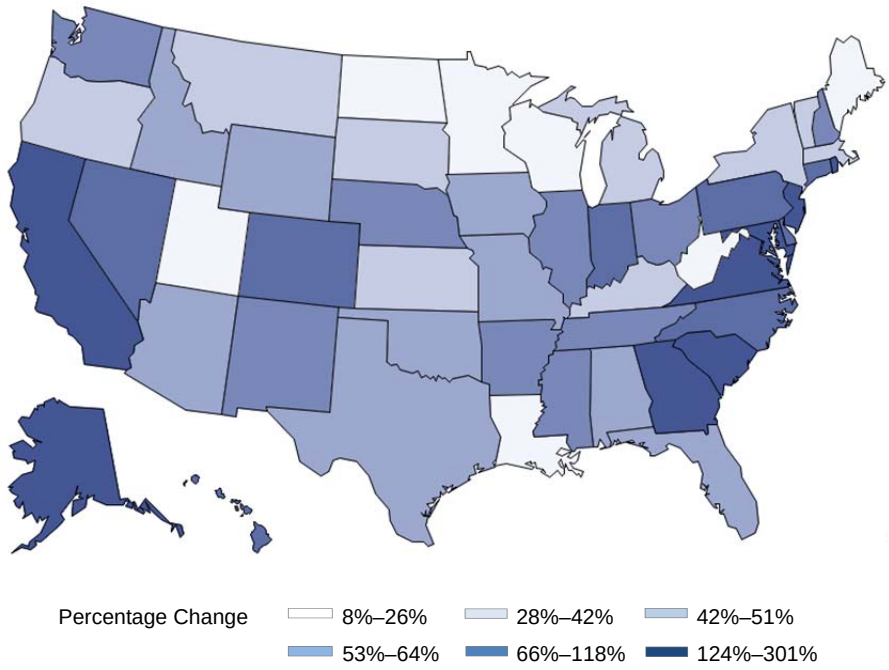
Although all States experienced increases in transports from 2002 to 2011, utilization changes varied widely by State. High-growth States experienced increases that were greater than the national increase in dialysis-related transports, BLS nonemergency transports, and inpatient hospital visits to treat renal failure in beneficiaries who received transports.

Among the States, the change in ambulance utilization varied from an increase of 8 percent in Utah to an increase of 289 percent in California. Ten States experienced increases of greater than 100 percent and six States experienced increases of 25 percent or less. Figure 2 illustrates the percentage change from 2002 to 2011 in ambulance utilization by State.

[45] Ambulance transports to partial hospitalization programs generally do not meet Medicare coverage requirements. Most beneficiaries do not meet the coverage criteria for both partial hospitalization programs and ambulance transports. For example, under a now-retired policy from Trailblazer Health Enterprises LLC, if a beneficiary was transported via ambulance because he was a danger to himself and/or others, he would not have been eligible for the partial hospitalization program. Trailblazer Health Enterprises, LLC, *Ambulance*, June 2012, pp. 61–62. (This policy is retired because Trailblazer Health Enterprises, LLC, is no longer a MAC.)

[46] We identified claims for inpatient hospital visits that were associated with beneficiaries' transports to hospitals. We report the conditions that represent at least 1 percent of all conditions that were treated during beneficiaries' inpatient visits.

Figure 2: Percentage Change From 2002 to 2011 in Ambulance Utilization by State



Note: Two territories experienced significant increases in ambulance utilization, and another territory experienced the only decrease in utilization. (Ambulance utilization increased 34,092 percent in Guam and 31,613 percent in the Northern Marianas, and decreased 71 percent in Puerto Rico.) However, these three territories together accounted for less than 1 percent of all transports in 2011.

Source: OIG analysis of 2002 to 2011 Medicare Part B ambulance transports, 2013.

In addition to the overall increase in the number of transports, changes in beneficiaries who received transports and supplier utilization also varied widely by State:

- Nationally, the number of beneficiaries who received transports increased 34 percent. Among the States, the change in the number of beneficiaries who received transports varied from an increase of 1 percent in Pennsylvania to an increase of 110 percent in California.
- Nationally, the average number of transports per beneficiary increased 26 percent. Among the States, the change in the average number of transports per beneficiary varied from a decrease of 1 percent in Vermont to an increase of 85 percent in California.
- Nationally, the number of suppliers increased 26 percent. Among the States, the change in the number of suppliers varied from a decrease of 25 percent in Mississippi to an increase of 207 percent in Virginia.
- Nationally, the average number of transports per supplier increased 34 percent. Among the States, the change in the average number of transports per supplier varied from a decrease of 20 percent in Virginia to an increase of 274 percent in California.

See Appendix C for the changes in these utilization measures for all States and territories. Appendix C also presents, for all States and territories, changes in the number of transports for each transport level and changes in the number of transports between

various origins and destinations.

After California, the other high-growth States were Virginia, South Carolina, Georgia, and New Jersey.[47] Ambulance utilization in these four States increased between 126 percent and 145 percent. Virginia, South Carolina, and Georgia each accounted for 3 percent of transports in 2011, and New Jersey accounted for 5 percent. The number of beneficiaries who received transports increased between 39 and 110 percent in the high-growth States. In contrast, the number of all Medicare fee-for-service beneficiaries increased between 8 and 24 percent in those same States.

The increase in dialysis-related transports in the high-growth States was much greater than the national increase. Beneficiaries who received transports in the high-growth States received between 329 percent and 6,920 percent more dialysis-related transports in 2011 than in 2002. Nationally, dialysis-related transports increased 269 percent. The greatest increase in dialysis-related transports occurred in South Carolina. In 2002, 2 percent of South Carolina's transports were dialysis-related, a share that grew to 48 percent in 2011. Additionally, the numbers of beneficiaries with ESRD who received transports in the high-growth States increased between 83 and 166 percent.[48] In four of the five high-growth States, this increase exceeded the national increase of 85 percent. Table 6 presents the changes in dialysis-related transports, the percentage of 2011 transports that were dialysis-related, and changes in the number of beneficiaries with ESRD who received transports within each of the five States and nationally.

Table 6: Percentage Change in Dialysis-Related Ambulance Transports and Beneficiaries with ESRD Who Received Transports From 2002 to 2011

State	Percentage Change in Dialysis-Related Ambulance Transports	Percentage of 2011 Transports That Were Dialysis Related	Percentage Change in Beneficiaries With ESRD Who Received Transports
National	**269%**	**19%**	**85%**
South Carolina	6,920%	48%	83%
California	2,727%	28%	166%
Georgia	1,138%	33%	102%
Virginia	329%	26%	133%
New Jersey	857%	29%	127%

Source: OIG analysis of 2002 to 2011 Medicare Part B ambulance transports, 2013.

The increase in BLS nonemergency transports in the high-growth States was greater than the national increase. The high-growth States experienced increases in BLS nonemergency transports ranging from 126 percent to 554 percent. Nationally, BLS nonemergency transports increased 94 percent. The greatest increase in BLS nonemergency transports occurred in California. In 2002, 31 percent of California's transports were BLS nonemergency transports, a share that grew to 53 percent in 2011.

[47] Ambulance utilization in Maryland and Alaska increased 138 percent and 136 percent, respectively, but accounted for 1 percent and less than 1 percent of all 2011 transports, respectively.

[48] In contrast, the numbers of all Medicare fee-for-service beneficiaries with ESRD in these States increased between 18 and 36 percent.

Table 7 presents the changes in BLS nonemergency transports within each of the five States and nationally.

Table 7: Percentage Change in BLS Nonemergency Ambulance Transports From 2002 to 2011

State	Percentage Change, 2002–2011	Percentage of 2011 Transports
National	**94%**	**46%**
California	554%	53%
Georgia	301%	51%
South Carolina	218%	68%
New Jersey	144%	71%
Virginia	126%	51%

Source: OIG analysis of 2002 to 2011 Medicare Part B ambulance transports, 2013.

In the high-growth States, the increase in the number of inpatient hospital visits to treat renal failure in beneficiaries who received transports was greater than the national increase. High-growth States experienced increases in the numbers of inpatient hospital visits to treat renal failure in beneficiaries who received transports. These increases ranged from 184 percent to 403 percent. Nationally, the number of inpatient hospital visits to treat renal failure in beneficiaries who received transports increased 158 percent. The greatest increase occurred in Virginia. In 2002, 1 percent of Virginia's inpatient visits associated with transports to hospitals were to treat renal failure, a share that grew to 3 percent in 2011.

CONCLUSION

Payments for ambulance transports from 2002 to 2011 increased 130 percent, compared to the 74-percent increase in overall Medicare Part B payments. Increases in the utilization of ambulance transports are disproportionate in relation to increases in the population of Medicare fee-for-service beneficiaries.

We found that—among many significant changes from 2002 to 2011—dialysis-related transports were much more common in 2011 than in 2002, increasing 269 percent. In addition, beneficiaries with ESRD who received transports used a growing and disproportionate amount of transports each year. Further, the number of Medicare fee-for-service beneficiaries with ESRD who received transports increased 85 percent from 2002 to 2011. In contrast, the number of all Medicare fee-for-service beneficiaries with ESRD increased only 24 percent during that period. We found that high-growth States experienced increases in dialysis-related transports greater than the national increase. Although dialysis facilities are a covered destination, transports to them do not usually meet coverage requirements under Medicare.[49]

We did not determine whether the utilization changes described in this memorandum report were appropriate, that is, whether transports met Medicare coverage requirements. In a forthcoming report, OIG will identify ambulance suppliers that exhibited questionable billing characteristics in the first half of 2012 and geographic areas with high numbers of these suppliers.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-09-12-00350 in all correspondence.

[49] Novitas Solutions, Inc., *Ambulance (Grounds) Services L32252*.

APPENDIX A

Detailed Data Analysis Methodology

We calculated the change in beneficiary, supplier, and transport characteristics from 2002 to 2011.

Beneficiary characteristics. We used the 2002 to 2011 Denominator files to determine the percentage of Medicare fee-for-service beneficiaries who received ambulance transports. We calculated the total number of beneficiaries who received transports. We calculated the average number of transports per beneficiary. We calculated beneficiaries' average age and the percentage of beneficiaries in each Medicare eligibility category using the date of birth and eligibility category reported on each claim.[50] As another measure of beneficiaries' utilization, we also calculated the percentage of transports received by beneficiaries in each Medicare eligibility category.[51]

Supplier characteristics. We calculated the total number of ambulance suppliers. We defined an ambulance supplier as each unique provider identification number, combined with a Medicare Administrative Contractor identification number, in our population of ambulance claims.[52] We calculated the average number of transports per supplier. In addition, we calculated the percentages of each supplier's transports that were billed with each procedure code, that is, the supplier's breakdown of transport levels. We identified suppliers for which at least 75 percent of the supplier's transports were billed with the procedure code for a single transport level.

Transport characteristics. Using CMS's Physician/Supplier Part B claims file, we calculated the frequency of the different transport levels, the frequency of transport origins and destinations, the average transport length in miles, and the beneficiary's medical condition at the time of transport. We determined the origin and destination using the two-letter modifier on the claim. We calculated the average transport length in miles. We determined the beneficiary's medical condition at the time of transport by analyzing the International Classification of Diseases code on each ambulance claim.

[50] For 2011 only, we used the Enrollment Database file to identify the beneficiary's eligibility category.
[51] People can become eligible for Medicare if they are 65 years or older. People under 65 years old can become eligible for Medicare if they are disabled and/or have ESRD.
[52] We did not use the National Provider Identifier because it was not required before May 2008 and therefore could not have been used to identify unique suppliers in all the years included in our scope. The provider identification number is unique only within each Medicare Administrative Contractor's jurisdiction; combining the provider identification number and the Medicare Administrative Contractor identification number allowed us to identify unique suppliers.

Detailed Data Analysis Methodology, *continued*

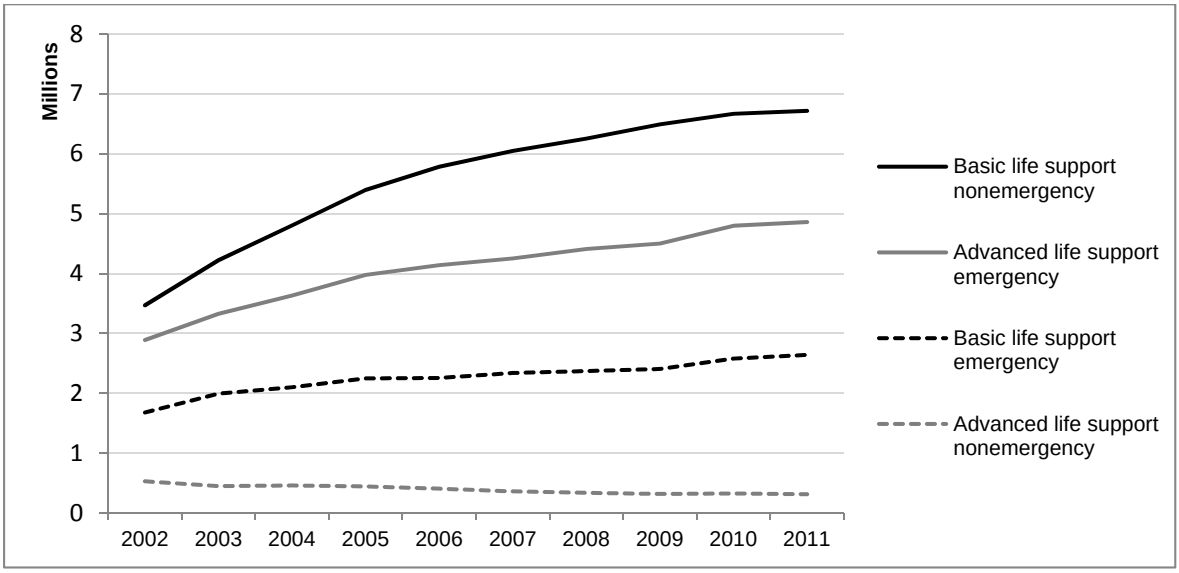
We analyzed the type of visits (inpatient or outpatient) made by beneficiaries who received transports to hospitals. We identified claims from CMS's Inpatient and Outpatient 100-percent Standard Analytic Files that were associated with transports to hospitals. We considered an inpatient claim to be associated with the transport if the beneficiary health insurance claim number matched the number on the transport claim and the inpatient admission date was within 2 days of the transport. If the transport did not have an associated inpatient claim, we determined whether the transport had an associated outpatient claim. We considered an outpatient claim to be associated with the transport if the beneficiary health insurance claim number matched the number on the transport claim and the date of service was within 31 days of the transport. We allowed the additional days for associated outpatient claims because transports may be provided during an outpatient billing period (for example, during a skilled nursing facility stay). If the transport had multiple associated outpatient claims, we chose the outpatient claim with the date of service that was closest to the date of the transport. For associated outpatient claims, we analyzed the type of bill to determine the most common type of outpatient facility that provided medical services to the beneficiary. For associated inpatient claims, we determined the most common Medicare severity diagnosis related groups (condition) of the inpatient stays.

Characteristics of utilization growth in States with the highest growth. We assigned each transport to a State based on the beneficiary's residence ZIP Code reported on the claim. We assigned each ambulance supplier to a State based on the majority of its transports. For each State, we calculated the change from 2002 to 2011 in the number of transports, number of beneficiaries who received transports, average number of transports per beneficiary, number of suppliers, and average number of transports per supplier. We also calculated the change during this period by State in the frequency of transports of different levels and transport origins and destinations.

We identified the States with the largest utilization increases that also accounted for at least 3 percent of 2011 transports nationally (high-growth States). We determined the extent to which these high-growth States experienced changes from 2002 to 2011 that differed from the national changes in transport destinations, transport levels, and medical services received by beneficiaries who received transports to hospitals.

APPENDIX B

Number of Ambulance Transports From 2002 to 2011 for Selected Transport Levels



Source: OIG analysis of 2002 to 2011 Medicare Part B ambulance transports, 2013.

Note: Three of the seven transports levels (paramedic advanced life support intercept, advanced life support 2, and specialty care transport) are not shown in this figure because collectively they represented less than 2 percent of all transports each year.

APPENDIX C

Table C-1: Percentage Changes From 2002 to 2011 in Utilization Measures by State

State	Number of Ambulance Transports	Number of Beneficiaries Who Received Transports	Average Number of Transports per Beneficiary	Number of Ambulance Suppliers	Average Number of Transports per Ambulance Supplier
National	**69%**	**34%**	**26%**	**26%**	**34%**
Alabama	49%	26%	18%	-13%	71%
Alaska	136%	108%	13%	93%	22%
Arizona	42%	33%	6%	-4%	48%
Arkansas	63%	48%	10%	-1%	65%
California	289%	110%	85%	4%	274%
Colorado	77%	52%	16%	6%	66%
Connecticut	70%	37%	24%	21%	40%
Delaware	118%	74%	25%	19%	83%
District of Columbia	301%	239%	18%	-50%	702%
Florida	46%	23%	18%	7%	36%
Georgia	133%	44%	61%	13%	107%
Guam	34,092%	693%	4,214%	*	*
Hawaii	95%	77%	10%	0%	95%
Idaho	46%	34%	10%	77%	-17%
Illinois	64%	45%	13%	41%	16%
Indiana	118%	36%	60%	31%	66%
Iowa	42%	31%	8%	12%	26%
Kansas	42%	30%	9%	4%	37%
Kentucky	41%	22%	15%	37%	3%
Louisiana	20%	11%	7%	4%	15%
Maine	26%	14%	10%	1%	25%
Maryland	138%	103%	17%	24%	91%
Massachusetts	41%	30%	9%	1%	39%
Michigan	41%	12%	25%	16%	22%
Minnesota	25%	13%	10%	-16%	48%
Mississippi	53%	36%	12%	-25%	104%
Missouri	50%	42%	6%	11%	35%
Montana	33%	23%	8%	6%	26%
Nebraska	61%	42%	14%	37%	18%
Nevada	71%	53%	12%	10%	55%
New Hampshire	53%	35%	13%	5%	46%
New Jersey	126%	42%	59%	75%	29%

*We assigned each ambulance supplier to a State based on the majority of the supplier's claims. Using this method, the State had zero suppliers in 2002 and/or 2011.

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Table C-1: Percentage Changes From 2002 to 2011 in Utilization Measures by State, *continued*

State	Number of Ambulance Transports	Number of Beneficiaries Who Received Transports	Average Number of Transports per Beneficiary	Number of Ambulance Suppliers	Average Number of Transports per Ambulance Supplier
New Mexico	54%	38%	12%	1%	53%
New York	31%	9%	20%	23%	6%
North Carolina	83%	56%	17%	87%	-2%
North Dakota	24%	10%	13%	-1%	25%
Northern Marianas	31,613%	413%	6,088%	*	*
Ohio	54%	27%	21%	60%	-4%
Oklahoma	51%	42%	7%	-19%	87%
Oregon	38%	23%	12%	41%	-3%
Pennsylvania	66%	1%	64%	1%	64%
Puerto Rico	-71%	-58%	-33%	72%	-83%
Rhode Island	124%	83%	23%	41%	60%
South Carolina	140%	39%	73%	93%	24%
South Dakota	40%	29%	8%	5%	34%
Tennessee	64%	35%	22%	24%	32%
Texas	51%	31%	15%	46%	3%
Utah	8%	2%	5%	11%	-3%
Vermont	28%	29%	-1%	9%	18%
Virgin Islands	83%	29%	42%	-33%	174%
Virginia	145%	96%	25%	207%	-20%
Washington	60%	43%	12%	86%	-14%
West Virginia	22%	7%	14%	-1%	23%
Wisconsin	24%	7%	15%	3%	20%
Wyoming	51%	39%	9%	2%	48%

*We assigned each ambulance supplier to a State based on the majority of the supplier's claims. Using this method, the State had zero suppliers in 2002 and/or 2011.

Source: OIG analysis of 2002 to 2011 Medicare Part B ambulance transports, 2013.

Table C-2: Percentage Changes From 2002 to 2011 in the Number of Transports in Each Transport Level by State

State	ALS Nonemergency (A0426)	ALS Emergency (A0427)	BLS Nonemergency (A0428)	BLS Emergency (A0429)	ALS2 (A0433)	Specialty Care Transport (A0434)
National	**-40%**	**68%**	**94%**	**57%**	**18%**	**114%**
Alabama	-29%	38%	74%	45%	132%	196%
Alaska	22%	206%	124%	101%	8%	57%
Arizona	25%	50%	20%	39%	-31%	21%
Arkansas	-16%	95%	58%	67%	46%	205%
California	15%	180%	554%	157%	82%	371%
Colorado	-46%	96%	83%	87%	29%	-37%
Connecticut	1%	93%	65%	73%	-69%	58%
Delaware	-34%	85%	109%	134%	100%	22%
District of Columbia	137%	2,898%	53%	1,598%	3,333%	500%
Florida	-60%	58%	69%	34%	4%	229%
Georgia	-18%	58%	301%	97%	2%	394%
Guam	0%	274%	143,200%	117%	*	*
Hawaii	210%	134%	117%	18%	32%	329%
Idaho	35%	53%	65%	33%	128%	-12%
Illinois	5%	99%	44%	62%	122%	72%
Indiana	32%	91%	183%	36%	-24%	283%
Iowa	-36%	56%	31%	61%	21%	61%
Kansas	-23%	53%	9%	64%	10%	71%
Kentucky	-4%	46%	49%	28%	25%	-22%
Louisiana	-47%	18%	27%	39%	77%	612%
Maine	-26%	37%	20%	30%	-56%	124%
Maryland	21%	201%	108%	235%	91%	5%
Massachusetts	14%	84%	29%	33%	-8%	151%
Michigan	-24%	32%	70%	28%	17%	309%
Minnesota	-13%	28%	-3%	47%	-21%	-51%
Mississippi	-20%	38%	69%	322%	25%	367%
Missouri	-46%	71%	36%	89%	70%	7%
Montana	-40%	55%	-7%	28%	149%	92%
Nebraska	12%	52%	39%	89%	399%	-71%
Nevada	-21%	106%	8%	21%	63%	54%

*The State had zero transports billed under that particular transport level in 2002 and/or 2011.

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Table C-2: Percentage Changes From 2002 to 2011 in the Number of Transports in Each Transport Level by State, *continued*

State	ALS Nonemergency (A0426)	ALS Emergency (A0427)	BLS Nonemergency (A0428)	BLS Emergency (A0429)	ALS2 (A0433)	Specialty Care Transport (A0434)
New Hampshire	12%	61%	48%	59%	10%	38%
New Jersey	-69%	359%	144%	79%	525%	75%
New Mexico	-31%	72%	36%	45%	239%	63%
New York	-41%	39%	35%	27%	6%	69%
North Carolina	-33%	99%	75%	105%	161%	41%
North Dakota	-8%	32%	22%	24%	-38%	-71%
Northern Marianas	200%	900%	251,600%	40%	*	*
Ohio	-14%	89%	48%	37%	-33%	84%
Oklahoma	-32%	82%	16%	49%	97%	282%
Oregon	-35%	41%	26%	68%	29%	69%
Pennsylvania	-14%	17%	159%	16%	-19%	127%
Puerto Rico	-90%	6%	-74%	-51%	231%	-12%
Rhode Island	-90%	222%	92%	325%	214%	141%
South Carolina	-21%	57%	218%	87%	-5%	243%
South Dakota	-45%	76%	-10%	42%	-5%	32%
Tennessee	-46%	95%	65%	93%	-13%	712%
Texas	-83%	41%	106%	122%	19%	226%
Utah	-15%	27%	-26%	4%	-39%	-55%
Vermont	16%	77%	2%	9%	24%	41%
Virgin Islands	30%	1,347%	219%	-91%	*	17%
Virginia	-22%	238%	126%	165%	175%	4%
Washington	11%	82%	30%	81%	33%	3%
West Virginia	-3%	10%	26%	37%	-60%	111%
Wisconsin	12%	55%	29%	0%	40%	-17%
Wyoming	-42%	92%	53%	42%	140%	84%

*The State had zero transports billed under that particular transport level in 2002 and/or 2011.

Source: OIG analysis of 2002 to 2011 Medicare Part B ambulance transports, 2013.

Table C-3: Percentage Changes From 2002 to 2011 in the Number of Transports Between Various Origins and Destinations by State

State	Between a Hospital and Private Residence	Between a Hospital and SNF or Residential Facility**	Between Hospitals	From an Accident to a Hospital	Between an Independent Dialysis Facility and Private Residence	Between an Independent Dialysis Facility and SNF or Residential Facility
National	**51%**	**49%**	**53%**	**112%**	**264%**	**285%**
Alabama	25%	23%	32%	142%	297%	328%
Alaska	142%	138%	133%	289%	*	*
Arizona	29%	36%	102%	118%	2,665%	116%
Arkansas	48%	46%	44%	319%	288%	646%
California	173%	277%	164%	146%	3,255%	2,652%
Colorado	74%	62%	58%	136%	1,670%	826%
Connecticut	77%	61%	35%	114%	184%	86%
Delaware	144%	41%	112%	121%	604%	228%
District of Columbia	993%	41%	242%	3,709%	21,300%	432%
Florida	22%	48%	33%	114%	416%	407%
Georgia	51%	68%	27%	245%	2,125%	657%
Guam	7,655%	778%	220%	850%	*	*
Hawaii	125%	51%	-6%	137%	-13%	400%
Idaho	37%	96%	15%	31%	*	*
Illinois	87%	38%	51%	111%	291%	72%
Indiana	76%	67%	76%	65%	658%	458%
Iowa	45%	31%	57%	59%	*	-97%
Kansas	50%	25%	31%	65%	457%	-78%
Kentucky	12%	24%	65%	242%	189%	146%
Louisiana	28%	-2%	260%	41%	88%	107%
Maine	19%	16%	34%	78%	251%	77%
Maryland	179%	83%	91%	570%	3,824%	225%
Massachusetts	38%	14%	25%	159%	121%	178%
Michigan	24%	28%	19%	59%	949%	426%
Minnesota	33%	-1%	29%	58%	291%	102%
Mississippi	48%	34%	90%	67%	114%	168%
Missouri	53%	35%	76%	97%	502%	-16%
Montana	28%	60%	23%	44%	-39%	-99%
Nebraska	52%	94%	45%	47%	*	-47%
Nevada	69%	76%	104%	98%	-67%	551%
New Hampshire	43%	35%	58%	123%	1,840%	280%
New Jersey	122%	35%	26%	267%	1,129%	607%

*The State had zero transports billed with that particular origin and destination in 2002 and/or 2011.

**"Residential facilities" refers to residential, domiciliary, or custodial facilities and includes, for example, assisted living facilities.

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Table C-3: Percentage Changes From 2002 to 2011 in the Number of Transports Between Various Origins and Destinations by State, *continued*

State	Between a Hospital and Private Residence	Between a Hospital and SNF or Residential Facility**	Between Hospitals	From an Accident to a Hospital	Between an Independent Dialysis Facility and Private Residence	Between an Independent Dialysis Facility and SNF or Residential Facility
New Mexico	42%	23%	42%	149%	7,640%	444%
New York	23%	17%	-5%	83%	399%	281%
North Carolina	67%	94%	57%	116%	173%	59%
North Dakota	-6%	18%	23%	222%	*	*
Northern Marianas	8,600%	*	*	0%	*	*
Ohio	73%	17%	66%	132%	272%	156%
Oklahoma	70%	25%	79%	58%	260%	42%
Oregon	14%	107%	28%	45%	3,650%	214%
Pennsylvania	16%	19%	41%	36%	1,436%	422%
Puerto Rico	-51%	20%	-63%	20%	-67%	9%
Rhode Island	313%	60%	22%	478%	132%	78%
South Carolina	59%	83%	45%	48%	9,659%	4,535%
South Dakota	47%	28%	17%	38%	1,500%	*
Tennessee	41%	35%	80%	126%	186%	162%
Texas	56%	95%	72%	35%	-33%	108%
Utah	-1%	-5%	74%	27%	*	5,350%
Vermont	27%	27%	73%	92%	*	579%
Virgin Islands	37%	77%	108%	-27%	*	*
Virginia	170%	83%	63%	362%	427%	253%
Washington	43%	71%	86%	109%	192%	137%
West Virginia	1%	17%	47%	104%	103%	79%
Wisconsin	15%	27%	50%	20%	226%	298%
Wyoming	46%	35%	67%	91%	*	500%

*The State had zero transports billed with that particular origin and destination in 2002 and/or 2011.

**"Residential facilities" refers to residential, domiciliary, or custodial facilities and includes, for example, assisted living facilities.

Source: OIG analysis of 2002 to 2011 Medicare Part B ambulance transports, 2013.